

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI

34479

FILED SEP 26 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2209

300 0
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Normandy Village</u>		c. CITY OR TOWN <u>St. Louis</u>	
OR TOWN <u>Normandy Village</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>43 Normandy Osteopathic</u>		d. STREET ADDRESS (If outside, give location) <u>5025 Waterman</u>	
Length of stay in 1b <u>10 days</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Birdie Ella Parker</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1893</u>
9. AGE (In years last birthday) <u>64</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Home</u>	
11. BIRTHPLACE (City and state or country) <u>Seventy Six, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Daniel Rhyne</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Arthur Parker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Faye Voss, 5715 Waterman Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Medullary Failure</u> DUE TO (c) <u>Myocardial Rupture</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Coronary Thrombosis; Diabetic Acidosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u> <u> sudden</u> <u> sudden</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>11:30</u> a.m. <u>pm</u> Month, Day, Year			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY <u>Seventy Six, Mo.</u> STATE	
21. I attended the deceased from <u>June 1957</u> to <u>9/4/57</u> and last saw ^{her} <u>him</u> alive on <u>9/3/57</u> Death occurred at <u>11:30 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Herbert H. Dornhe</u> (Degree or title) <u>2</u>		22b. ADDRESS <u>5307 Pershing, St. Louis 12 Mo</u>	
22c. DATE/SIGNED <u>9/4/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-4-57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Shilo Cemetery</u>		23d. LOCATION (City, town, or county). (State) <u>Seventy Six, Mo.</u>	
24. FUNERAL DIRECTOR <u>Albert H. Hoppe, 4700 Washington Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>9-4-57</u>	
26. REGISTRAR'S SIGNATURE <u>Herbert H. Dornhe M.D.</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

acc

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4194
P. O. Address, St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting. --

If this body is not embalmed, fact should be so stated above.